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U.S. Army-Baylor University Graduate Program in Health and Business Administration

Policy Options for Sharing Activities Between the Department of Veterans Affairs and the
Department of Defense: A Graduate Management Project
Presented to Dr. Karin Zucker

In Partial Fulfillment of
U.S. Army-Baylor University Graduate Program in Health and Business Administration

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Abstract

The Department of Veterans Affairs and the Department of Defense have failed to advance sharing efforts to the extent that the legislative and executive branches of the United States Government intended since the Veterans Administration and the Department of Defense Health Resources Sharing and Emergency Operations Act was passed in 1982. Although numerous barriers exist to increased sharing, a fundamental one that exists in both organizations is the structural inertia inherent in large bureaucracies. Against the backdrop of a rapidly changing health care environment in the United States, the model of punctuated equilibrium was employed as means of determining those circumstances more likely to bring about transformational, revolutionary organizational change along the lines envisioned by the executive and legislative branches. As a result, the adoption of federal policy calling for compulsory, large-scale sharing throughout all domains of both the VA and the DOD health care organizations is recommended. Adoption of this policy is the best means of ensuring cost efficiency, greater access to care, and quality care for the health care beneficiaries of both the Department of Veterans Affairs and the Department of Defense.

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Introduction

Together, the Department of Veterans Affairs (VA) and the Department of Defense (DOD) provide health care services to more than 12 million beneficiaries at a cost of more than \$53 billion per year (United States General Accounting Office [USGAO], 2004a). The two systems represent an enormous investment in federal health care dollars, with the VA operating 154 hospitals and more than 800 clinics and the DOD operating 70 hospitals and 411 clinics (Brewin, 2006). More than 20 years ago, in 1982, Congress formally recognized the potential for savings to be achieved through increased sharing of resources between the VA and the DOD and passed the Veterans Administration (VA) and the Department of Defense Health Resources Sharing and Emergency Operations Act (USGAO, 2004a and 38 U.S.C. § 8111). The “Sharing Act” was intended to promote “the more cost-effective use of health care resources and more efficient delivery of care” (USGAO, 2004a, para. 1). To accomplish these goals, the Sharing Act established an environment in which fewer legal barriers existed to sharing and in which incentives were provided for the Departments to engage in sharing through local agreements, joint ventures, national sharing initiatives, and other collaborative efforts. The Sharing Act gave health care executives flexibility in conducting negotiations and developing reimbursement procedures at the local and national level. Finally, in an effort to remove one of the largest impediments to enhanced sharing, the Sharing Act made it possible for health care facilities to retain any savings accrued as a result of sharing agreements (United States House of Representatives [USHOR], 2002).

Although numerous opportunities for sharing have existed in the more than 20 years since the Act’s passage, numerous barriers remain that continue to hinder the VA and the DOD from reaching the level of sharing and integration envisioned by both the legislative and

executive branches of the United States Government (USGAO, 2000a). Although the VA/DOD annual report to Congress in January 2000 described the VA/DOD sharing efforts as a strong program with “virtually all” VA and DOD facilities taking part, in fact, the reality is much different. While the dollar volume and the number of agreements have increased substantially over the past 20 years, the total amount of sharing remains miniscule as a percentage of the two Departments’ combined budgets. In 2000, this equated to a mere two-tenths of 1% of their combined medical spending (USHOR, 2002). In 2006, the VA’s health care budget was approximately \$32 billion (Congressional Research Service [CRS], 2006, p. 15) and the DOD’s was approximately \$23 billion (Congressional Budget Office [CBO], 2003). The 2006 target for dollars exchanged between the two organizations of \$143 million (Kelly, L., personal communication, November 9, 2006) represents slightly more than two tenths of 1% of the gross combined health care budgets. Little has changed.

Since the early 1980s, it has been the VA’s statutory role to “provide backup for the DOD health system in war or other emergencies...”(Bascetta, 2001, p. 2). In fiscal year 2001, less than one-half of 1% of VA’s total health care budget was allocated to that mission.

Equally telling, although not quantitative in nature, are the 2005 annual reports to the Office of Management and Budget¹ submitted by separately by the VA and the DOD. Although the reports are intended to describe the progress made by each Department in collaborating with the other, the information described by each Department appears to have been generated independently of the other; i.e., the Departments’ descriptions of their sharing progress do not match. This is especially ironic given that the subject matter at hand is focused on collaboration (Department of Defense [DOD], 2005; Department of Veterans Affairs [DVA], 2005).

¹ The Office of Management and Budget is an executive branch agency that assists the President in managing and preparing the federal budget and in evaluating the effectiveness of agency programs, policies, and procedures (Office of Management and Budget, n.d.).

The VA and the DOD health care systems can be fairly described as controlling substantial health care budgets to operate a significant number of health care facilities for federal beneficiaries in an environment characterized by the need for reform and for the stewardship of taxpayer dollars as described in the President's Management Agenda, the document which codifies the Bush administration's strategy for improving government (President's Management Agenda [PMA], 2002). In this context, it is necessary to weigh the courses that the VA and DOD have charted towards limited, selective collaboration against the interests of the beneficiaries of the system, potential beneficiaries of both systems, and of the taxpayers footing the financial burden. This paper seeks to examine the evolution of VA/DOD sharing, recognize the barriers responsible for its slow adoption and growth, and recommend policy regarding future VA/DOD sharing efforts in light of current economic pressures and demographic trends. As Pogo, the popular comic strip character created by Walt Kelly in 1952, once humorously observed, "We are confronted with insurmountable opportunities" (Kelly).

Overview of VA/DOD Sharing Activities

Background

Before launching into a description of the wealth of literature concerning the shortcomings of VA and DOD efforts to collaborate, further elaboration on the compelling reasons for increased VA/DOD collaboration is required in order to establish the need for comprehensive, focused public policy on the matter. Thomas Garthwaite, Former Deputy Under Secretary for Health in the Department of Veterans Affairs testified to a Congressional Subcommittee that, "VA/DOD sharing has been widely recognized and endorsed as an effective means to provide better service to Federal beneficiaries cost effectively" (Garthwaite, 2000, para. 3). The question at hand is, "What characteristics do the VA and the DOD possess that compel

both the executive and the legislative branches of government to urge the two Departments to further their collaborative efforts?" To understand this, one must understand some key features of each health care system.

The VA and DOD operate health care systems that are, in many ways, quite similar. The DOD's military health system (MHS) has responsibilities associated with two different, but overlapping, missions:

- Readiness – To provide, and to maintain readiness to provide, medical services and support to the armed forces during military operations.
- Benefits – to provide medical services and support to members of the armed forces, their dependents, and others entitled to DOD medical care (Rand, 2002).

The VHA's mission was formulated by President Abraham Lincoln: "To care for him who shall have borne the battle and for his widow and his orphan (*About VA*).” Based on these stated missions, one would readily infer that the DOD is responsible for providing health care to service members and their families *before* and *during* battle, and the VA is responsible for providing care and benefits to the service members and their families *after* the battle. This simple interpretation of each Department's mission is, generally, accurate. The connotation appears to be one of temporal progression, i.e., the care provided by the VA follows, in time, the care provided by the DOD. Certainly, the populations cared for by the two systems do sometimes overlap, as one population (VA) has its roots in the other (DOD) and, in fact, some individuals are legally eligible to receive care from both systems, a telling reminder of the inherent overlap in the populations (USGAO, 2003a).

One of the key characteristics of the care provided by the DOD system is that, of the 9.2 million TRICARE² eligible beneficiaries in 2005 (TRICARE, 2006), only 1.4 million receiving care were active duty personnel, while the remainder were comprised of other eligible beneficiaries, e.g., dependents, retirees, survivors, or non-enrolled users. In short, the vast majority of the care provided by the military health system is provided to non-active duty personnel – another characteristic shared by the VA. Military treatment facilities have, historically, provided approximately two thirds of the health care used by TRICARE beneficiaries overall (measured in terms of visits) and almost all of the health care used by active-duty personnel. Civilian providers supply the remainder of the care (RAND, 2002). Although treatment of war-related injuries constitutes an important part of the DOD's medical program, non-war-related care accounts for the overwhelming majority of DOD's medical spending. In 2003, spending on those programs that are specific only to military needs and have no analogs in private-sector health plans comprised *only 3%* (\$900 million) of the DOD's total medical spending (CBO, 2003). Said differently, the majority of the care provided to beneficiaries of the MHS has little to do with direct support of wartime activities.

Another similarity between the two systems is the tremendous amount of infrastructure each health care system currently has in place and the inadequate planning and development processes that exist for the improvement of existing capital investments. The two systems comprise approximately 250 hospitals and medical centers and approximately 1,400 ambulatory care facilities, amounting to almost 200 million square feet of space and representing \$50 billion in plant replacement value (Wilensky et al., 2003). Most of the VA's, and to a somewhat lesser degree the MHS's, facilities were constructed based on the outdated assumption that large

² TRICARE is the worldwide health care program of the Department of Defense. TRICARE serves active duty and retired uniformed services members and their families (Tricare: The Basics, 2003).

inpatient populations would be the norm. The VA invests less than 2% of its plant replacement value in capital improvements each year, while the DOD invests approximately 3.5%. It is generally agreed that a minimum of between 4% and 8% investment of plant replacement value is required in order to maintain a healthy infrastructure (Wilensky et al., 2003). Within the DOD, much of the management of health care infrastructure is being addressed through the Base Realignment and Closure process - a process which is resulting in the closure of some health care facilities and the realignment of others (Garamone, 2005). Similarly, the VA has employed the Capital Asset Realignment for Enhances Services (CARES) process to address "the appropriate clinical role of small facilities, vacant space, the potential for enhanced use leases and the consolidation of services and campuses (*Cares Business Plan Studies, n.d.*). Key members from both Departments have been involved in both the BRAC process and the CARES process (Schlossberg, G., 2005).

Finally, and most importantly, the key feature shared by both the VA and the DOD health care systems is the source of the majority of their respective budgets: The United States taxpayer. With health care costs spiraling upwards in the United States, the need for the judicious management of federal health care dollars is of vital importance. In a 2003 study conducted by the Congressional Budget Office, the DOD's future medical spending is projected to increase from the \$27 billion spent in 2003 to \$46 billion in 2020 (CBO, 2003). Under this scenario, the DOD would be spending 73 cents on medical benefits for every dollar in cash compensation by 2020. This increase, while significant, reflects only the midrange, potential increase rather than the highest, potential increase, an increase which would put DOD medical spending in 2020 at \$52 billion (CBO, 2003). These projections certainly sound a warning but should not come as a surprise given recent trends in increasing health care costs.

In fact, both the DOD and the VA have experienced alarming increases in health care expenditures in recent years. The VA's health care expenditures rose from \$12 billion in fiscal year 1990 to \$26.8 billion in fiscal year 2004. The DOD's health care expenditures increased from \$12 billion in 1990 to \$30.4 billion in 2004 (USGAO, 2006). Between 2001 and 2005, the costs for DOD health care doubled from \$18 billion to \$36 billion (Connolly, 2005). Of course, there are a number of reasons why health care costs are increasing in the VA, the DOD, and across the nation, including changes in technology, an imperfect market, defensive medicine, practice variations, etc. (Shi & Sing, 2004). A key factor affecting the nation's health care costs as a whole, and those of the VA and the DOD specifically, is the national demographic trend towards an aging population. 2000 Census Bureau projections for the United States show that the over-65 age group, which in 2000 numbered approximately 35 million, will grow to 40 million by 2010 and will double to 70 million by 2030. The over-85 age group will also double to approximately 9 million by 2030 (Institute of Medicine [IOM], 2001). Within the VA, the veteran population that is most in need of nursing home care, i.e., veterans 85 years or older, is expected to increase from approximately 640,000 in 2003 to more than 1 million by 2012 and to remain at that level through 2023 (USGAO, 2003b).

Because the DOD manages the care of retirees and other beneficiaries, it is not exempt from the challenges of addressing the needs of an aging population. Between 1981 and 1996, for example, the share of beneficiaries in the MHS who were 65 years old or older grew from 5% to 15% of the eligible population (CBO, 1997, p. 18). By 2010, the costs for care for retirees within the MHS could reach 70% of the overall DOD health care budget (Connolly, 2005). Because older people make greater use of health care resources than younger people, the economic ramifications of the aging population are significant and will reflect a commensurate increase in

hospital visits and in the use of pharmaceuticals (Wilensky et al., 2003). Complicating the DOD budgetary issues still further is the need to manage the additional demand resulting from Congressional actions to expand eligibility for retirees, reservists, National Guard service members and their dependents, and the additional needs of those serving in Operation Enduring Freedom and Operation Iraqi Freedom (USGAO, 2006).

In fact, many of the VA and DOD facilities are currently indicating that they are operating at, or over, capacity. The nature of sharing, then, has shifted from an environment of excess capacity in 1982 when the Sharing Act was passed to one of limited capacity. The 1982 environment called for sharing in order to make better use of excess space; the environment today calls for sharing in order to make better use of limited, overlapping, and often redundant resources. Today's environment calls for partnering and gaining efficiencies through leveraging resources and joint buying power (USGAO, 2006).

The recognition by Congress that the budgets represented overlapping missions, populations, and costs was manifested in a change from the review of the budgets in separate House of Representative Committees prior to 2006, to the simultaneous review of both the VA and the DOD budget appropriations in a single committee, the newly formed Military Quality of Life/Veterans Affairs Appropriations Subcommittee (The Library of Congress, 2006). It is the opportunity that exists to achieve cost savings and cost avoidances through increased sharing of resources between the Departments that represents the primary reason for the call for additional sharing.

So, with overlapping missions, population demographics becoming more homogenous, overlapping geography, and limited resources derived from taxpayer contributions, the two Departments have been poised for increased sharing and collaboration for several years. As

stated in the President's Management Agenda, "Over time, numerous programs with overlapping missions and competing agendas grow up alongside one another-wasting money and baffling citizens" (OMB, 2002, p. 3).

Criticisms of Current Sharing Efforts

Because the mandate to increase sharing between the VA and the DOD has been extant for so many years, and because much of the discussion related to VA/DOD sharing occurs in the upper echelons of the U.S. Government, there is a wealth of literature describing the multitude of efforts made to date to increase, enhance, modify, or otherwise improve collaborative efforts between the VA and the DOD. Much of the literature is the result of routine reports to the Congress by the Government Accounting Office, now the Government Accountability Office³ (GAO), and the Office of Management and Budget (OMB). Many of these reports come in the form of testimony to various congressional subcommittees. In the case of testimony by the Government Accountability Office, the title of the report often speaks volumes. For example, in the 2000 Government Accountability Office testimony titled, "Rethinking of Resource Sharing Strategies is Needed," the Government Accountability Office notes that while the VA and DOD report the number of facilities that have entered into a sharing agreement, they fail to capture the actual volume of services exchanged (USGAO, 2000b). In a 2001 report to congressional committees regarding VA/DOD and Indian Health Services' efforts to enhance health data sharing, the Government Accountability Office reports that the Government Computerized Patient Record (GCPR) called for by the President in 1997 had "raised doubts regarding the GCPR's ability to provide its expected benefits," a remark made 4 years following the President's call for the enhanced data sharing (USGAO, 2001, p. 1). Similarly, in a 2006 report

³ The Government Accountability Office is an independent, non-partisan investigative arm of Congress that studies federal program activities and makes recommendations intended to render government more effective and responsive (*What is GAO*, n.d.).

titled, "Opportunities to Maximize Resource Sharing Remain" the Government Accountability Office notes that two key councils formed to facilitate collaboration and sharing activities between the VA and the DOD, the Joint Executive Council and the Health Executive Council, "have not seized upon a number of opportunities to further collaboration and coordination" (USGAO, 2006, para. 2).

At the pinnacle of the document "pyramid," the President's Management Agenda (hereinafter Agenda) appears to be the impetus behind much of the VA/DOD sharing occurring today. The Agenda, developed in 2001, outlines five government-wide initiatives, and several program initiatives targeted at improving government performance. Relevant to this paper is the program initiative titled, "Coordination of VA and DOD Programs and Systems," which addresses overlapping beneficiary populations and changing demographics. More specifically, in 2001, more than 600,000 military retirees eligible for DOD care were also enrolled in the VA for care, posing challenges in resource planning for both agencies. As was described earlier, the beneficiary population cared for by the DOD is aging and looking more and more like the population traditionally cared for by the VA. As the beneficiary populations of both systems become more homogeneous, the Agenda calls for more cooperation between the two systems to include buying and selling services, shared staffing, advanced technology, education and training, consolidated procurement, pharmaceuticals, etc. It bemoans the fact that "so far, few of these opportunities have been put to use" and calls for the improved coordination of health care and the elimination of potentially duplicative budgeting through the sharing of data between VA and DOD (OMB, 2002, p. 69). It is important to note that the Agenda confers no additional authority on the systems to share, rather, it acts as a reminder that VA/DOD sharing is a priority of the current administration.

In 2003, the final report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans was released. The report indicates that, due to a variety of factors, the demand for care from the VA and the DOD will continue to increase. In part, this is due to the rising cost of health care and rising insurance premiums and other economic pressures. This report, while recognizing the VA and the DOD for sharing efforts to date, admonishes each for failing to send a unified, clear message that describes the expected end state of collaboration and sharing. The report indicates that clearer leadership is needed and that "the goal is not collaboration for its own sake, but rather, to collaborate so as to improve access to quality health care and reduce the cost of furnishing services" (Wilensky et al, 2003). That statement is especially telling in that it implies that much of the sharing occurring to date has been pursued simply so that key personnel can say that sharing is occurring rather than to reduce costs and improve health care quality. The report acknowledges the efforts made by the VA and the DOD to contract jointly for pharmaceuticals but goes on to say that, by most measures, VA/DOD sharing efforts have been mixed (Wilensky et al, 2003).

In 2001, a Bill entitled the Department of Defense-Department of Veterans Affairs Health Resources Access Improvement Act of 2001 was placed before the House of Representatives (H.R. 2667[107]) by Republican Christopher Smith of New Jersey in an effort to promote and advance increased sharing activities between the VA and the DOD. The Bill stated:

(4) The Secretary of Defense and the Secretary of Veterans Affairs, and the appropriate officials of each of those Departments with responsibilities related to health care, have not taken full advantage of the opportunities provided by law to make their respective health resources available to health care beneficiaries of the other Department in order to provide improved health care for the whole number of beneficiaries.

(5) After the many years of support and encouragement from Congress, the Departments have made little progress in health resource sharing and the intended results of the sharing authority have not been achieved (Smith, 2001).

Barriers to Sharing

It is clear that the literature supports the notion that the level of sharing and collaboration between the VA and the DOD health care systems is insufficient in the eyes of the Government Accountability Office and the Congressional Budget Office and, *a posteriori*, the legislative and executive branches. Having established that progress towards increased sharing between the VA and the DOD has been slow and has not met the intent of either the legislative or the executive branches of government, it becomes important to present some of the barriers that have been identified in the literature as contributing to the failure to advance sharing at the pace desired by Congress, the President, the Government Accountability Office, the Office of Management and Budget, etc.

The 2002, Staff Report to the Committee on Veterans Affairs identifies poor guidance; restrictive regulations; incompatible methods of cost reimbursement; absence of sharing goals; incompatible computer systems; and, most importantly, an absence of statutory requirements for health resources sharing. In other words, while the way had been paved for increased sharing via the Sharing Act of 1982, as late as 2002, no mandate yet existed that instructed the agencies to actually share. This astonishing lack of direction is also exemplified in Veterans Healthcare Administration (VHA) Handbook 1660.4 titled, *VA-DOD Health care Resources Sharing* which states, "VA facilities and military treatment facilities are required to *consider* entering into agreements or contracts with each other" (DVA, 2004). Other barriers described by the President's Task Force to Improve Health Care Delivery For Our Nation's Veterans in 2003

include incongruities in organizational structure, budgeting processes, health care delivery plans, acquisition plans, and facility plans (Wilensky et al., 2003). These barriers do not reflect an exhaustive list of the reasons cited for the retarded progress between the Departments; however, to cite the content of the numerous documents and correspondence that identify such barriers would be redundant, since an exhaustive analysis of the available literature yields comparable observations and criticisms across all sources.

Recommendations to Advance Sharing Efforts

To summarize, it can be seen that legislation exists that supports VA/DOD sharing and, despite the legislation, little progress has been made, as demonstrated by the perennial admonishments by the Government Accountability Office and the Office of Management and Budget to increase the levels of collaboration. Also, the barriers to sharing have been identified in multiple sources over the course of several years. This begs the question, "What actions, then, need to be taken to truly increase VA/DOD sharing to the extent envisioned by the legislative and executive branches?" Once again, an abundance of literature exists that clearly identifies, over the course of several years, actions that were deemed necessary in order to advance VA/DOD sharing at a more rapid, meaningful pace. Some of these documents have already been mentioned.

In 2000, the General Accounting Office made several recommendations that targeted both the VA and the DOD, as well as recommendations that targeted each Department specifically. In terms of joint recommendations, the VA and DOD were encouraged to conduct an assessment to determine the most cost-effective means of providing care to beneficiaries from the perspective of the federal government, rather than the perspective of either the VA or the DOD. Acknowledging the barriers that exist to enhance sharing, the General Accounting Office

called for the VA and the DOD to develop procedures that accommodate each Department's particular budgeting and resource management functions. Finally, the General Accounting Office recommended that procedures be put in place that measure the amount of sharing accomplished between the two Departments with respect to the volume and types of services provided, reimbursements collected, and costs avoided (USGAO, 2000a, p. 30).

In 2001, H.R. 2667 recommended that integrated management be instituted at five VA and DOD facilities located in close proximity to each other (H.R. 2667[107], 2001). The five facilities were to be selected jointly by the Secretary of Veterans Affairs and the Secretary of Defense. As part and parcel of the integrated management, a single budget and personnel system would be employed by the merged facilities, as well as a unified medical information and information technology systems. Under this Bill, VA facilities treating service members would have been considered military treatment facilities (MTFs) for the purposes of eligibility, and MTFs treating veterans would be considered VA facilities for the purposes of eligibility. The Bill further called for the construction of a new, jointly operated medical facility and the integration of graduate medical education programs. The Bill was not passed.

In 2002, in a Staff Report to the Committee on Veterans Affairs, recommendations were made to undertake demonstration projects to:

- Develop and implement integrated and compatible budgets, reimbursement methodologies, cost accounting systems and information technology systems;
- Create an information infrastructure that facilitates data exchange of patient health, financial and management information across the demonstration sites.
- Consolidate the employment and human resource management authorities of title 10 and title 38 of the U.S. Code.

- Develop a joint policy staff to identify needs based upon the combined VA-DOD beneficiary population in conjunction with each Department's missions;
- Establish a new federal facility in Charleston, SC, that consolidates the Charleston Naval Hospital, the Johnson VA Medical Center and the Medical University of South Carolina Academic Center.
- Consolidate VA health care currently provided at Womack Army Medical Center, Fayetteville, NC;
- Develop a joint patient medical record and combine the Government Computerized Patient Record initiative with the VA's Computerized Patient Record System and DOD's Composite Health Care System.
- Develop a "certificate of need"-type requirement for any VA or DOD capital medical acquisition or infrastructure requirements in the 21 co-located VA-DOD facility sites identified by the General Accounting Office.
- Mandate a specific savings goal, such as a quantified level of savings over 5 years based on their combined medical outlays nationwide (USHOR, 2002, p.11).

Finally, the report urged that legislation be considered that would "achieve improved access, readiness enhancement and greater efficiencies in this major health investment by the American people" (USHOR, 2002, p. 12). Specifically, it urged the adoption of House of Representatives Bill 2667, alluded to previously. The 2002 Staff Report's recommendations represent the most comprehensive, sweeping, and integrated approach to VA/DOD sharing of the broad array of recommendations made over the years.

In 2003, the President's Task Force made nine recommendations related to enhancing VA/DOD sharing. While the recommendations did call for the establishment of a joint

pharmaceutical formulary, the sharing of prescription-filling authority, and the joint acquisitions of products and services, the recommendations were, largely, non-specific. They implored the Departments to “improve the structural congruence between the two Departments” and “provide significantly enhanced authority, accountability, and incentives to health care managers at the local and regional levels in order to enhance standardized and collaborative activities that improve health care delivery and control costs” (Wilensky et al., 2003, p. 47). Perhaps the most interesting recommendation put forward by the task force admonished the VA and the DOD to “declare that joint ventures are integral to the standard operations of both Departments” (Wilensky, et al., 2003, p.60). This reproach only serves to call attention to the lack of progress made towards increased sharing in an environment that has, ostensibly, encouraged enhanced collaboration since 1982.

Recommendations made to enhance VA/DOD sharing culminated in a provision in the National Defense Authorization Act for Fiscal Year 2003 that required the VA and the DOD to implement two programs, the joint incentive program and the demonstration program. These programs, intended to increase the amount of health care resource sharing between the two Departments, came to be known as the Joint Incentive Fund and the Demonstration Site Selection programs. The programs require the Secretary of each Department to contribute a minimum of \$15 million from each Department’s appropriation into a U.S. Treasury account for each fiscal year, 2004 through 2007. The Financial Management Workgroup under the Health Executive Council is responsible for administering the programs, while the Government Accountability Office is responsible for providing a report to Congress on the program’s progress in February of each year (USGAO, 2005a).

A request for proposals was jointly issued by the DOD TRICARE Management Activity and the VA Medical Sharing Office and, as of February 25, 2004, 57 proposals had been submitted. These 57 proposals were considered “concept” proposals, representing a broad range of sharing activities, and required review by VA and DOD program officials prior to selection. Selection and evaluation criteria favored projects that addressed:

- DOD’s and VA’s joint, long-term approach to meeting the health care needs of their beneficiary populations
 - Improved beneficiary access
 - Exportability to other facilities
 - Maximizing the number of beneficiaries that would benefit from the initiative
 - Cost-savings or cost-avoidance
 - The development of in-house capabilities at a lesser cost for services now obtained by contract
 - The ability to become self-sustaining beyond the life of available incentive funds
- (USGAO, 2004b, para. 5.)

Of the final 58 proposals submitted, 29 were selected for a more detailed review. Officials at each site whose concept proposal was selected were then asked to submit another, more detailed proposal, with a business case analysis for review by the Financial Management Work Group. In August 2004, 12 of the 29 proposals were selected for implementation and nine were funded. Funding required a letter from project officials who certified that the project will be self-sustaining within 2 years or, if not, that other funding will be available to cover costs in future years.

Joint incentive fund projects experienced difficulty due to delays resulting from the initial absence of funding mechanisms (USGAO, 2006). According to the Government Accountability Office:

Disbursement of funds must follow Department-funding protocols and new accounts are created to track the funding. For DOD, the transfer of funds involves four sequential steps to move money from the Incentive Fund to DOD's Under Secretary of Defense (Comptroller); to TMA; to Departments' *[sic]* Surgeon General offices' health care resource managers; and to military treatment facilities responsible for the project. For VA, the transfer is made from the Incentive Fund to the VA medical center or program office responsible for the project (USGAO, 2005a, p.3).

The demonstration site selection program experienced challenges as sites reported difficulty developing project submission packages and experienced confusion regarding timelines and the approval process. Personnel also experienced frustration with the volume of paperwork required (USGAO, 2006). The complexities of participating in the joint incentive fund and demonstration site selection programs belie the fact that, ironically, the programs were intended to *facilitate* sharing. In November 2004, a second request for proposals was issued. The number of submissions dropped from 58 submitted in response to the first call, to 50 submitted in the second (USGAO, 2005a). As of December 2005, seven joint incentive fund and seven demonstration site selection projects were operational. Renewed in December 2007, the joint incentive fund and demonstration site selection projects are currently ongoing. A recurring complaint of the Government Accountability Office is that, despite the sharing progress being made at individual facilities utilizing joint incentive fund and demonstration site selection funding, the VA and the DOD "lack performance measures that would be useful for evaluating

how well they are achieving their resource-sharing goals” (USGAO, 2006, p. 30). Additionally, the Government Accountability Office criticizes the lack of an evaluation plan that documents and records the reasons for the advantages and disadvantages of each project. This information is critical if the results of projects at individual facilities are to be exported nationally (USGAO, 2006). Despite the money spent and the projects underway, it is unclear whether the sharing efforts undertaken at individual facilities are enhancing sharing efforts there, let alone whether they are enhancing sharing efforts nationally.

Private Sector Analogs

It is challenging to employ analogies as a means of clearly illustrating the circumstances surrounding the slow adoption of sharing between the VA and the DOD. Few meaningful comparisons can be made between federal and private sector organizations where sharing is concerned. This is because of the extensive regulatory restrictions limiting private sector sharing, compared to the relatively unexercised license for sharing that has been granted the VA and the DOD.

The VA/DOD sharing now underway is roughly analogous to the non-equity alliances found among many private sector companies. These alliances are contractual in nature, flexible (low commitment), and do not involve the purchase of one company’s shares by another. In contrast, an equity alliance involves one partner purchasing some of the other partner’s capital and involves greater commitment on the part of both parties (Coombs & Bierly, 2001). With substantial consolidation of outpatient and inpatient functions and a single chain of command, the integration of the North Chicago VA and Naval Hospital Great Lakes is the closest analog to an equity alliance in VA/DOD sharing. Despite the scale of the consolidation, however, revenue

streams for both participants remain separated (Spotswood, 2004). In VA/DOD sharing, there is no extant analog to acquisition, the most ambitious alliance found in the private sector.

Kolasky (1997), suggested that greater cooperation in the private sector has been driven by several factors, including the need to compete in the global economy, increasing economies of scale and scope, the need for organizations to concentrate on their core competencies, inherent complexities in key technologies, etc. Both private sector and public sector strategic alliances have in common the desire to take advantages of potential economies of scale and scope, but they differ in their vulnerabilities. In the private sector, the concern is that too much sharing of resources between, or among, organizations may constitute restriction of free trade and violate anti-trust laws. In the public sector, the concern is that insufficient sharing among publicly funded organizations may result in waste and inefficiencies.

In the VA/DOD environment, sharing activities fall into four categories:

- Local sharing agreements allow VA Medical Centers (VAMCs) and MTFs to exchange health and support services to maximize their resources.
- Joint venture sharing agreements, like private sector joint ventures, aim to avoid costs by pooling resources to build new facilities or capitalize on existing facilities.
- National sharing initiatives are developed by the Health Executive Council. The Council's goal is to identify and implement initiatives that are national in scope. Generally, such initiatives are intended to identify duplicative activities by both Departments.
- Other collaborative efforts, such as the joint purchasing of pharmaceuticals by the Departments (GAO, 2000, p. 7).

Since direct analogs to federal sharing do not exist in the private sector because of differing regulations regarding their formation, perhaps employing a hypothetical situation that uses common terminology will serve to better illustrate federal sharing.

Imagine that a city operates two separate bus lines using taxpayer dollars. One bus line sees its mission as transporting middle school students, the other transports high school students. Often, the middle schools and high schools are located on the same campus, since the property was purchased by the same entity, the city. The population served overlaps, the routes and geography often overlap, and they are funded by the same source. Now, imagine that the city demands that the bus lines consider engaging in some sharing activities that would avoid duplication and save taxpayer dollars. The two bus lines will, on occasion, loan one bus to another bus line, and will, on occasion, share drivers on some routes. The city will eventually ask itself the inevitable question, "Why do we even have two bus lines?" Although this analogy is unable to entirely reflect the enormous complexity of VA/DOD sharing, it should serve to illustrate to the reader the state of VA/DOD sharing as perceived by many in the legislative and executive branches of government.

Policy Options

Theories of Organizational Change

In order to adequately understand why the VA and the DOD have been slow to progress in sharing efforts, it is necessary to place the problem in an appropriate context. The failure of the VA and the DOD to adopt an aggressive and responsive pace towards increased sharing can certainly be attributed, in part, to the barriers discussed previously, such as poor guidance, restrictive regulations, incompatible methods of cost reimbursement, an absence of sharing goals,

incompatible computer systems, and an absence of statutory requirements for health resources sharing.

In a statement to the Committee on Veterans' Affairs, Under Secretary for Defense, David S.C. Chu, also identified different missions and different populations as barriers to collaboration with the VA (Chu, 2003). In an environment where different missions and populations are listed as barriers to collaboration with the VA, the DOD is undergoing its own internal growing pains as support for a unified medical command grows. Under the current proposal, a single, unified command would control the Army, Navy, and the Air Force, rather than having separate medical commands for each service (Philpott, 2006). The intent of the integration is to curb the \$500 million in annual waste that occurs in the medical commands through duplication of effort, according to the Center for Naval Analyses. The parallels between the desire to implement a unified medical command and the desire for more VA/DOD collaboration are obvious. Lt. General James Roudebush, the Air Force Surgeon General, has argued that service cultures and missions are sufficiently different to justify having separate medical staffs and resources. The barriers to VA/DOD collaboration as described by Undersecretary Chu are strikingly similar to those described by Lt. General Roudebush for integration within the DOD. While a unified medical command is not yet reality, it may be difficult for naysayers to sell to the Secretary of Defense the idea that collaboration within the DOD's own services is not practical, but collaboration between the DOD and the VA is. In fact, Lt. General Roudebush's arguments were soundly trounced, perhaps a tacit recognition that they have little merit and reflect an organizational resistance to change rather than insurmountable obstacles (Philpott, 2006).

Attributing the slow adoption of sharing to the litany of barriers that has been repeated over the years is challenged by the fact that VA/DOD sharing is, indeed, occurring, albeit in a non-uniform fashion across the United States, with some sites sharing much more than others (USGAO, 2004b). Although not routinely discussed in literature specifically addressing VA/DOD sharing, a potential, underlying reason is the inherent cultural resistance to change of both organizations. The Government Accountability Office has described the DOD as having “a tradition of remarkable military achievement but it also has an entrenched culture that resists dramatic changes from well-established patterns of behavior” (USGAO, 1997, p. 13). Likewise, the VA was recently described by the Secretary of Veterans Affairs, Jim Nicholson, as having a “long-standing resistance to change...” (Pulliam, 2006, para. 5). Clearly, a legislative environment conducive to sharing does exist and has existed since the Sharing Act of 1982; however, some facilities (in both Departments) are more amenable to the adoption of change, while others are resistant as evidenced by the concentration of sharing efforts at just a few facilities (USGAO, 2004b). This resistance to change is not surprising. According to Hammer (as cited by Ainsley and Riordan, 1999, p. 135),

“Most bureaucratic organizations have been designed for stability. They were organized and managed with the belief that fundamental change does not happen—that the future of the organization is basically the same as its past, and the goal of management is to maintain and perfect the model that was originally designed.”

Fortunately, the information available on the dynamics of change within organizations is rich and diverse. In 1948, Coch and French identified a number of ways in which resistance to change is manifested in the workplace. Their work was the first to address the role played by participatory management in reducing an organization’s resistance to change (Elrod & Tippet,

2002). Lewin's model for organizational change, posthumously published in 1952, describes change in organizations as occurring in three phases: (a) unfreezing, (b) movement, (c) freezing (Robbins, 2003, p. 564). Since then, several individuals have developed models in an effort to describe and understand organizational change, including Finstand in 1998, Weick in 1995, Starbuck in 1976, Dimaggio in 1998, and Zucker in 1987 (as cited by Gustafson et al., 2003). In a landmark work, Romanelli and Tushman (1994) effectively demonstrated that the punctuated equilibrium model espoused by Gersick in 1991, Miller and Friesen in 1980, and Tushman and Romanelli in 1985 was empirically shown to be accurate. For the purposes of this paper, the punctuated equilibrium model most succinctly and completely describes how effective organizational change occurs, and it lends insight into why the adoption of more rapid sharing between VA and DOD has not taken place. It also offers insight as to possible policy options designed to redirect sharing efforts.

Punctuated Equilibrium

The punctuated equilibrium model as described by Miller and Frisen (as cited by Romanelli & Tushman, 1994) shows that organizations that radically and quickly alter their formal structures, decision-making processes, and information-processing models are more successful than organizations that change gradually or incrementally. Proponents of the general theory of punctuated equilibrium argue that the usual state of organizational activity is one of stability or equilibrium. Organizations will establish a pattern of activity based on the prevailing environmental conditions at the time the decisions were made by management during the organization's founding. Then, with organizational inertia and institutionalization fully set in, organizations develop "coherent systems of shared understandings that support continuation of the established patterns" (Romanelli & Tushman, 1994, p. 1143). According to the model of

punctuated equilibrium, “radical and discontinuous change of all or most organizational activities is necessary to break the strong grip of inertia” (Romanelli & Tushman, 1994, p. 1143).

Theorists employing the model of punctuated equilibrium often contrast their prediction of pervasive, discontinuous transformation with non-revolutionary, gradual, or incremental transformation. Cyert and March (as cited by Romanelli & Tushman, 1994, p. 1143) described incremental or gradual transformation as “individual subunits of organizations dealing incrementally and disjointedly with one problem and one goal at a time while emphasizing short-run reaction to short-run feedback.” Organizational sub-units, which could be departments, medical centers, etc., are interdependent. However, when change is implemented incrementally, the change does not cause sub-units to adapt to the change in a cascade-like or domino fashion; rather, they resist the change as they seek to maintain their complex network of relationships and commitments. This resistance to change is pivotal in the theory of punctuated equilibrium, since it is this resistance that establishes a key condition supporting revolutionary transformation.

How, then, can organizational transformation be stimulated, especially in organizations that have strong structural inertia? Oster and Boeker (as cited by Romanelli & Tushman, 1994, p. 1144) showed that organizations tend to maintain their current activity pattern when their performance is either good or improving. Harrigan (as cited by Romanelli & Tushman, 1994, p. 1144) showed that organizations tend to alter their activity pattern when their performance is poor or declining. It has also been shown that incumbent management teams may minimize the importance of declines in performance and seek to explain them as simply a need for additional resources. The punctuated equilibrium model suggests that “only large or long-sustained declines in performance are likely to trigger fundamental organizational transformations

(Romanelli & Tushman, 1994, p. 1144). Additionally, the environment in which an organization operates can have a significant impact on an organization's transformation.

Meyer, et al. (as cited by Romanelli & Tushman, 1994, p. 1145) have explored the effect of disruptive environmental jolts that alter an organization's operating and competitive environments. Through longitudinal studies of hospitals, they concluded that jolts to the operating and competitive environment do, in fact, tend to provoke organizational crises that facilitate revolutionary transformation. Finally, the punctuated equilibrium model has shown that changing an organization's chief executive, even in the absence of declining performance or substantive environmental change, will increase the likelihood of organizational transformation. This is largely because new chief executive officers, especially those coming from outside organizations, tend to be uncommitted to the policies and strategies established by their predecessors.

In summary, the key points of the model that should be considered in the development of new sharing policy are:

1. Organizational transformations will most frequently occur in short, discontinuous bursts of change involving most or all key domains of organizational activity.
2. Small changes in individual domains of organizational activity will not accumulate incrementally to yield a fundamental transformation.
3. Major declines in the short-term performance of an organization or sustained declines over several years will substantially increase the likelihood of revolutionary transformation.
4. Major changes in environmental conditions will significantly increase the likelihood of revolutionary transformation.

5. Installation of a new chief executive officer will significantly increase the likelihood of revolutionary transformation (Romanelli & Tushman, 1994, p. 1143).

It is in the context of these five key points of the punctuated equilibrium model that new policy should be developed for VA/DOD sharing efforts. Clearly, the VA and the DOD, because of their ages, sizes, scopes, and cultures, can be regarded as possessing tremendous structural inertia and institutionalization. Comparing the five elements of the model to the sharing efforts over the past 20+ years, the VA and the DOD have engaged in short, discontinuous bursts of change with regard to sharing; however, the bursts of sharing have failed to involve all key domains of organizational activity. Activity has usually been limited to relatively few key VA and DOD facilities, which could be regarded as Romanelli and Tushman's "subunits". In fact, in 2002, 75% of the \$62 million in sharing occurring between the VA and the DOD is derived from agreements at only 30 sites (USHOR, 2002) although the VA operates 154 hospitals and more than 800 clinics, and the DOD operates 70 hospitals and 411 clinics (Brewin, 2006).

The most recent efforts to enhance VA/DOD sharing as described under the National Defense Authorization Act of 2003 are directly contrary to the second point in the punctuated equilibrium model. As previously described, the National Defense Authorization Act of 2003 arranged for the solicitation of projects from interested facilities and then funded some of those projects with the hopes that the efforts of the projects that were successful could then be exported to other interested VA and DOD facilities. This sort of incremental change has been shown to be unsuccessful in yielding large-scale transformation.

The third point in the model recognizes that an organization's poor performance will facilitate transformation. The July 17, 2006 issue of *Business Week* described the VA as

providing the best medical care in the United States, with low costs, high quality, and the most advanced computerized patient record system in the United States. For the past 6 years, The VA has outranked private-sector hospitals on patient satisfaction in an annual consumer survey conducted by the National Quality Research Center despite VA's expenditures of approximately \$5,000 per patient, compared to the national average of \$6,300 (Arnst, 2006, p. 1). The August 27, 2006 issue of TIME magazine describes VA hospitals as "the best" (Waller, 2006, Title) and notes that "[m]ales 65 years and older receiving VA care had about a 40% lower risk of death than those enrolled in Medicare Advantage, whose care is provided through private health plans or HMOs" (Waller, 2006, para. 3). In this sense, one might regard the good performance of the VA as a barrier to large-scale transformation, since it may be perceived that effecting such large-scale change might compromise existing success.

The fourth point asserts that major change in the environmental and operating conditions of an organization will increase the likelihood of revolutionary transformation. Clearly, the pressures that are faced by both organizations constitute major changes in the environmental and operating conditions. As has been previously described, health care costs are increasing for both organizations for several reasons, most notably the changing demographics associated with an aging population. In the context of the fourth point, the stage has been set for revolutionary change, although it is debatable whether the current environmental circumstances affecting both Departments are significant enough to compel Congress and the Executive Branch to effect substantive change.

Finally, the installment of a new chief executive officer is strongly associated with revolutionary transformation. In the context of the two Departments, it is unclear whether this characteristic applies, as new chief executive officers, in the form of Departmental Secretaries,

come and go with new administrations, while little comprehensive and system-wide change in VA/DOD sharing has occurred for more than 20 years since the Sharing Act was adopted.

The general role of the punctuated equilibrium model in organizations has now been explored, as has the model's specific application to VA/DOD efforts. It is now possible to express policy options that can set the direction of future VA/DOD sharing efforts

Three Policy Options

Three policy options that should be considered given the current state of VA/DOD sharing are:

1. Status quo: Under this option, no changes are made to the current practice of incremental, non-mandatory change as is supported under the National Defense Authorization Act of 2003.
2. Abandonment: Under this option, despite potential future costs savings and efficiencies, the barriers are too numerous and the timing poor for the two health systems to work towards increased sharing. Pressure from Congress and the Executive Branch to further sharing efforts is lifted, and facilities are encouraged to manage their populations independently and to the best of their ability. In those situations where sharing is already occurring, it is permitted to continue, however, no partner is in any way compelled to continue sharing efforts.
3. Compulsory sharing: Under this option, in accordance with the model of punctuated equilibrium, the only means of effecting transformational change in both organizations is to apply the changes radically, drastically, and across all subunits (health care facilities) simultaneously. This option calls for sweeping, rapid,

mandatory, uniform change at all levels of both organizations. The adoption of sharing at all levels is non-optional, and written into law.

Evaluative Criteria

Because the primary reason for pursuing sharing activities is achieving cost-savings and/or cost-avoidance, it makes sense to adopt *cost-efficiency* as an evaluative criterion to aid in determining whether a particular policy option has merit. Measuring cost-efficiency is different, however, from measuring cost. Currently, the VA and the DOD routinely report on the number of dollars exchanged between the organizations as a measure of organizational sharing (Winkenwerder, 2005). While this provides limited insight into the volume of sharing as a percentage of gross budgets, it does not describe cost efficiency. A better means of expressing cost-efficiency would be to routinely report costs that were incurred as a result of sharing versus costs that *would have been* incurred without sharing. In this fashion, the costs avoided become apparent; the avoided costs are, essentially, monies that can be spent on other health care needs.

A second criterion that should be adopted is *access*. In an environment where resources are scarce and sharing is intended to make more efficient use of those limited resources, it is imperative that economies of scope be taken into account, as well as economies of scale. With economies of scope, as the number of products available is increased, more people can be reached with each dollar spent. Within the health care arena this equates to offering additional services. For example, rather than the VA purchasing an additional item of radiology equipment, perhaps it would make more sense for a nearby DOD facility to purchase that equipment and provide services to veterans, obviating the need for the VA to invest in additional infrastructure. Veterans that may have been sent to another VA several miles away for the same procedure could, then, be seen at the nearby DOD facility. While some of this type of sharing does occur

today, it is not mandatory. Access is routinely measured in both the VA and the DOD by measuring waiting times before obtaining an appointment (Tricare, 2006, DVA, 2004).

It is not coincidental that two of the criteria represent two of the three “cornerstones of health care delivery,” *cost, access, and quality* identified by Al-Assaf (as cited by Shi & Singh, 2004, p. 484). Nor is it coincidental that the third criterion selected is, then, *quality*. This is simply because quality care is less expensive, in the long run, than poor quality care (National Committee for Quality Assurance, 2005). It follows, then, that improving the quality of care delivered to beneficiaries has the positive effect of reducing costs in the long run. Quality, therefore, ties into cost and, ultimately, into access. Quality of care can be measured by a facility’s compliance with care guidelines, commonly referred to as clinical practice guidelines⁴. Clinical practice guidelines represent the state-of-the-art in evidence-based medicine (Guideline [medical], 2006). Those who adopt and execute the guidelines and operate within their requirements are said to provide quality care, those who do not, are not. A second means of measuring quality is patient satisfaction, however, it is possible that a patient could receive quality care based on the application of evidence-based medicine and still be unsatisfied. So, for the purposes of this paper, the measurement of quality will be limited to clinical practice guidelines.

These three evaluative criteria, taken together, will act as meaningful, quantitative measuring tools to assess the merit of each of the three policy options.

Projected Outcomes

Table 1 entitled *Projected Outcomes for Policy Options by Evaluative Criteria* illustrates the projected outcomes of the application of the aforementioned criteria to each of the

⁴ Clinical practice guidelines are “standardized guidelines in the form of scientifically established protocols representing preferred processes in medical practice” (Shi & Singh, 2004, p. 599).

Table 1

Projected Outcomes for Policy Options by Evaluative Criteria

Policy Option	Cost Efficiency		Access		Quality
	Dollars exchanged between VA and DOD as a percentage of gross budgets	Costs saved/avoided	Waiting times for primary care appointment	Waiting times for specialty care appointment	
Status Quo	This figure will increase incrementally over the coming years but will not represent a substantial percentage of gross budgets	This figure will increase incrementally over the coming years.	As resources become more scarce and as populations age, this number will increase over the coming years.	As resources become more scarce and as populations age, this number will increase over the coming years.	As resources become more scarce and as populations age, it will become more difficult to comply with the growing number of clinical practice guidelines.
Abandonment	With no pressure to continue sharing efforts, this number will decrease over the coming years.	With no pressure to continue sharing efforts, this number will decrease over the coming years.	With no pressure to continue sharing efforts, this number will increase over the coming years.	With no pressure to continue sharing efforts, this number will increase over the coming years.	As resources become more scarce and as populations age, it will become increasingly difficult to comply with the growing number of clinical practice guidelines.
Compulsory Sharing	This figure will increase significantly over the coming years, ultimately representing a significant percentage of gross budgets.	This figure will increase substantially over the coming years.	As resources become more scarce and as populations age, this number will improve or, at least, not worsen over the coming years.	As resources become more scarce and as populations age, this number will improve or, at least, not worsen over the coming years.	As resources become more scarce and as populations age, it will become increasingly difficult to comply with the growing number of clinical practice guidelines. Under compulsory sharing, this number would initially worsen but ultimately improve.

three policy options described above. Should the status quo be maintained, the amount of money exchanged between the VA and the DOD in sharing efforts will continue to increase over the coming years; however, the amount will continue to be insignificant as a percentage of the combined gross budgets of both Departments. Under this option, the costs saved and avoided will increase incrementally over the coming years, but will not, in all likelihood, achieve their potential given the history of sharing efforts, the observations by the Government Accountability Office that describe the VA's and the DOD's failure to capitalize on sharing opportunities, and the model of punctuated equilibrium. Likewise, access will become a greater challenge as resources become more scarce and as the average age of the populations of both Departments continues to rise. Similarly, as more evidence-based medicine is transformed into clinical practice guidelines and more guidelines are adopted, it will become more difficult to meet the requirements set out in them and to provide uniform, quality care. Compounding the matter is, once again, the impact of aging populations on both Departments and those populations' inherent requirement for more complex, expensive care.

Should the abandonment option be employed, the amount of money shared between the VA and the DOD as a percentage of gross budgets will decrease. History has shown that, without obvious economic benefits and/or urging by the legislative/executive branch, little sharing occurs. On the other hand, it is not clear that abandoning sharing efforts would result in increased costs, since the role of TRICARE in the DOD and the role of community-provided care in the VA is growing (TRICARE, 2006; USGAO, 2005b). It may be that turning to the community-at-large for much of the beneficiary care now being provided by the VA and the DOD could result in cost savings. The same can be said for issues related to access; without pressure to continue sharing, opportunities for economies of scope between the agencies will

probably be overlooked and waiting times for one or both populations will increase unless the private sector plays a substantially greater role in providing care to the VA/DOD beneficiary populations. As with the status quo option, it will become more and more difficult to comply with the requirements of clinical practice guidelines in the context of aging populations. Should the VA and the DOD look increasingly to the community for health care for their beneficiaries in lieu of providing in-house care, the uniformity of the application of clinical practice guidelines comes into question as well.

Under the compulsory sharing option, the amount of money exchanged between the two systems would increase significantly in the coming years. Likewise, the amount of money saved and costs avoided would also increase significantly. Significant economies of scale and of scope could be achieved. On the other hand, the efforts of the joint incentive fund and the demonstration site selection program have shown that investment funding is required to implement even minor change. In order to execute compulsory sharing, a significant amount of "seed money" would need to be invested in order to further integrate the two health care systems and address many of the structural barriers described earlier in this paper. Elrod and Tippet (2002) showed that appropriate organizational change will initially cause reduced productivity (output per worker) but, will ultimately results in improved productivity. Costs avoided and saved would, when measured against the required investment, be initially small but subsequently increase. Compulsory sharing between Departments would improve access by making available to each of the populations the expertise of the other Department providing them care. During a transition period, waiting times may worsen somewhat, however, they would ultimately improve. The same can be said of the adoption of, and compliance with, clinical practice guidelines. Because of the VA's expertise with an older population, the VA could lend its expertise to the

DOD in complying with the requirements of managing such a population. Initially, compliance would worsen, but would ultimately improve.

Analysis of Trade-offs

At first blush, one might assume the trade-offs associated with the projected outcomes shown in Table 1 would be obvious; i.e., an improvement in quality would come at the expense of a proportional increase in cost and potential decrease in access. It is worth reiterating, however, that quality care is less expensive, in the long run, than poor quality care (National Committee for Quality Assurance, 2005). With that in mind, an analysis of trade-offs is not a zero-sum exercise across all possible outcomes. Stated differently, a positive outcome may not necessarily occur at the expense of another outcome. The outcomes shown in Table 1 can be visualized as points along continuum with little or no progress represented by the abandonment option, slightly more progress with the status quo option, and the most progress represented by the compulsory sharing option.

While this asymmetrical analysis of trade-offs may be counterintuitive to some, the implications are important and worth noting: Increases in quality will, ultimately, result in decreases in cost. Any outcome that has a negative impact on quality will, ultimately, result in an increase in cost. Interestingly, because of the aging populations of both Departments and the concomitant demand for increased access to health care, it is a foregone conclusion that costs will continue to increase. Emphasis must, then, be placed on the reduction of costs through increased efficiencies and improved quality. It is important to note here that an increase in cost or an increase in access does not necessarily imply a commensurate increase in quality.

Because cost and quality are inextricably linked, the question must be asked, "How does one determine meaningful trade-offs among the various outcomes?" In order to answer this

question, one must return to the fundamental reason that the legislative and executive branches espoused the idea of VA/DOD sharing in the first place, i.e., a perceived need to gain efficiencies and achieve cost savings and cost avoidances. Recognizing that any efforts towards achieving cost efficiencies in any system must be addressed in the context of the both current and projected expenditures, any analysis of outcome trade-offs must consider whether there would be gains in short-term costs or benefits at the expense of gains in long-term costs or benefits - or vice versa. For the purposes of this analysis, a short-term duration is regarded as being less than 5 years, and a long-term duration is regarded as being greater than 5 years.

Under the status quo option, cost, access, and quality will continue to marginally increase in both the short and long term, but will do so at the expense of greater cost, access, and quality increases that can be gained under the compulsory sharing option.

Under the abandonment option, the short-term reduction in expenses and reduction in operational complexity come at the expense of long-term savings that can be achieved, to a lesser degree, via the status quo option or, to a greater degree, via the compulsory sharing option.

Under the compulsory sharing option, however, the improvements in cost, access, and quality come at the expense of increased short-term costs. As described earlier, compulsory sharing accomplished through change on the scale supported by the Romanelli and Tushman model would require significant investments beyond the \$15 million now required annually by both Departments as a result of the National Defense Authorization Act of 2003.

Recommendation

Based on the information gathered through this analysis it is recommended that the compulsory sharing option be adopted as United States health care policy in the framework of the punctuated equilibrium model and that large-scale sharing and integration of VA and DOD

resources be pursued across all VA and DOD health care domains. Only this particular policy option will address the need to manage the spiraling health care costs experienced by the VA and the DOD, as well as to provide the infrastructure, economies of scale, and economies of scope necessary to meet future access needs and quality care requirements. This recommendation is supported by the application of the punctuated equilibrium model which notes that “organizational transformations will most frequently occur in short, discontinuous bursts of change involving most or all key domains of organizational activity” (Romanelli & Tushman, 1994, p. 1143). This recommendation is further supported by the preponderance of literature, previously described, that characterizes large-scale sharing between the VA and the DOD as an unfulfilled goal of both the executive and the legislative branches.

This recommendation does not stand on its own, however. It reiterates the failure of the current, incremental approach to sharing through the joint incentive fund and the demonstration site selection projects (USGAO, 2005a). Once again, “[s]mall changes in individual domains of organizational activity will not accumulate incrementally to yield a fundamental transformation” (Romanelli & Tushman, 1994, p. 1143).

Additionally, this recommendation is made because of the likelihood of its success based on the punctuated equilibrium model which suggests that “[m]ajor changes in environmental conditions will significantly increase the likelihood of revolutionary transformation” (Romanelli & Tushman, 1994, p. 1143). Neither the status quo or abandonment options represent revolutionary transformation. It is clear that the health care environment in the United States, generally, and within the VA and the DOD, specifically, is changing rapidly. With U.S. health care costs at a staggering 16% of the gross domestic product, health care providers in the United States are under enormous pressure to more carefully manage costs (National Coalition on

Health Care, n.d.). The aging beneficiary populations of both the VA and the DOD (USGAO, 2003b; Connolly, 2005) should be seen as a model of the overall U.S. population's demand for health care. With costs spiraling for both Departments (USGAO, 2006), business-as-usual will no longer suffice.

Recent events have highlighted the changing VA/DOD health care environment in a fashion that must be addressed separately from the aforementioned spiraling costs and demographic trends. On February 18, 2007, reporters from the Washington Post published an article describing the poor living conditions at Walter Reed Army Medical Center endured by nearly 700 service members (Priest, 2007), most of whom were veterans of the global war on terror. In addition to moldy walls, vermin infestation, and other environmental concerns, several issues brought to light related to access to care, administrative confusion, overcrowding, etc. Although the incident was regarded as overblown by some (Schmidt, 2007), it resulted in the firing of the Secretary of the Army and the dismissal of two medical facility commanders (Abramowitz, 2007). Perhaps because many reports (accurately) describe the service members at Walter Reed as veterans, confusion mounted as to whether Walter Reed was operated by the VA or the DOD (SourceWatch, 2007). This confusion may have been compounded when the President, in the wake of the Walter Reed incident, created an interagency task force headed by the Secretary of Veterans Affairs with the task of reviewing and improving the processes encountered by veterans seeking benefits when returning from the Global War on Terror. Although this interagency task force was only one of three bodies with an investigative mandate, some interpreted the appointment of the VA Secretary as the head of the task force as a partisan effort to downplay the VA's overall success, since that success may contradict the more conservative belief that government cannot, and should not, play a large role in providing health

care (Sourcewatch, 2007). Margaret O’Kane, president of the National Committee for Quality Assurance (as quoted by Waller, 2007, para.12) says that it is becoming more and more “ideologically inconvenient for some to have such a stellar health-delivery system (VA) being run by the government”.

The implications of the Walter Reed situation are enormous. It illustrates the public’s interest in health care for service members and the confusion regarding where the DOD health care system ends and the VA begins. The rapid response of the DOD and the executive branch to resolving the Walter Reed issues and the inclusion of the VA in the solution could be interpreted in many ways; however, it is clear that the administration is sensitive to the need for the proper treatment of service members and veterans and to the public’s perception of their treatment. The Global War on Terror and the resultant, increased sensitivity to the care of service members and veterans has caused the VA/DOD health care environment to become linked in a new and extremely public fashion (Benjamin, 2007). These dramatic changes in the health care environment act as yet another building block in the foundation of revolutionary transformation of VA/DOD health care as prescribed by punctuated equilibrium.

Finally, the punctuated equilibrium model notes that “[m]ajor declines in the short-term performance of an organization or sustained declines over several years will substantially increase the likelihood of revolutionary transformation” (Romanelli & Tushman, 1994, p. 1143). It is clear that the changing environment in health care could readily precipitate a dramatic decline in the performance of both VA and DOD health care. While such declines would precipitate dramatic change in accordance with the punctuated equilibrium model, in this circumstance it would be wise to adhere to the words of the English proverb admonishing us to “[m]ake hay while the sun shines” (Henry, 1945, p. 174). The need to ensure that our nation’s

service members and veterans have access to quality health care now, and in the future, is sufficiently compelling that waiting for declines in performance to precipitate large-scale change would be imprudent, serving neither the health care beneficiaries or the U.S. taxpayers.

Conclusion

In summary, the DOD and the VA have failed to advance sharing efforts to the extent that the legislative and executive branches of the United States Government intended since the Sharing Act was passed in 1982. Although numerous barriers exist to increased sharing, a fundamental barrier to change that exists in both organizations stems from the structural inertia inherent in large bureaucracies. Against the backdrop of a rapidly changing health care environment in the United States, the model of punctuated equilibrium was employed as means of determining those circumstances more likely to bring about transformational, revolutionary organizational change. As a result, it is recommended that compulsory, large-scale sharing throughout all domains of both the VA and the DOD health care organizations is the best means of ensuring cost efficiency, greater access to care, and quality care for the health care beneficiaries of both the VA and the DOD.

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